DOCUMENT RESUME

ED 405 684 EC 305 384

| | |
|---|---|
| AUTHOR | Bonilla, Carlos A., Ed.; Goss, Joyce, Ed. |
| TITLE | Public (K-12) Education's Hot Jalapenos. Topics Picantes in Special Education. |
| REPORT NO | ISBN-1-879774-03-8 |
| PUB DATE | 97 |
| NOTE | 50p. |
| AVAILABLE FROM | ICA, Inc., 1020 N. Commerce, Stockton, CA 95202 ($19.95; quantity discount). |
| PUB TYPE | Collected Works - General (020) |
| EDRS PRICE | MF01/PC02 Plus Postage. |
| DESCRIPTORS | *Attention Deficit Disorders; Behavior Modification; *Biofeedback; *Disabilities; *Drug Therapy; Elementary Secondary Education; Hyperactivity; *Inclusive Schools; Intervention; Mainstreaming; *Public Education; Social Integration |
| IDENTIFIERS | Ritalin |

ABSTRACT

This monograph contains two papers which address the controversial issues of drug therapy for children with attention deficit/hyperactivity disorder (ADD/ADHD) and full inclusion of children with disabilities in regular education. The first paper, "Club MED: Diagnosis ADD/ADHD" (Lynne A. Phillips et al.), explores the ramifications of over-diagnosis of ADD and ADHD and the alternatives to drug therapy for affected children. A brief discussion of the recent escalation of diagnosis and medication of children with ADD is given. The paper then offers a teacher's perspective and a behavioral modification guide. An alternative to drug treatment, biofeedback, is discussed. The second paper, "Full Inclusion: One Size Fits All?" (Lisa Dondero et al.) summarizes in the first section the legal bases for inclusion efforts, describes successful implementation in a program which includes students of all ability levels in a multi-age format, and identifies essential components of successful programs. The second section raises pros and cons of inclusive education, including positive peer models, "learned helplessness," improved social acceptance, low academic achievement, protection of all students from those with severe behavior disorders, the inherent inequality of separate education, the necessity of aides and a support system, and the high costs of such support systems. The paper concludes that a continuum of services must be provided to meet the individual needs of each child. (Each paper contains references.) (DB)

**********
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
**********

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED 405 684

# PUBLIC (K-12) EDUCATION'S

# HOT JALAPEÑOS

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY
C. Bonilla
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Carlos A. Bonilla, PhD and Joyce Goss, B.A.,Editors

Contributors: Regular and Special Education Teachers

* An ICA, Inc. Occassional Monograph in Education
© 1997

EC 305 324



BEST COPY AVAILABLE

# Topics Picantes in Special Education

- Club Med.

  The ADD-ADHD/Ritalin Riddle

  &

- Full Inclusion

  Does one Size Fit All?

ISBN: 1-879774-03-8

*Public (K-12) Education's Hot Jalapeños*

**Copyright ©1997**
**All rights reserved. Printed in the United States of America. No part of this book may be used or reproduced in any form or by any means, or stored in a database or retrieval system, without written permission of the publisher except in the case of brief quotations embodied in critical articles and reviews. Making copies of any part of this book for any purpose other than your own personal use is in violation of United States copyright laws.**

**For information write:**

**ICA Inc**
**1020 N. Commerce**
**Stockton, Ca. 95202**

**ISBN: 1-879774-03-8**

**Library of Congress Catalog Card number: 96-79027**

## The Two Hot Jalapeños

- Full Inclusion:

> Special Education, without a doubt, has become the most expensive item in education budgets.
>
> It, full inclusion, forces teachers-not trained to effectively handle these matters-to change diapers and colostomy bags, and to deal with violence-prone children.

**How do <u>teachers</u> feel about this?**

- ADD/ADHD and Ritalin:

> ...if misused on children without the disorder who are simply discipline problems for teachers or parents, the drugs [Ritalin] would stimulate, not tranquilize, them."
>
> *The New York Times,* April 25, 1991
>
> ...Schoolchildren are being diagnosed and medicated for the disorder [ADD] in too cavalier a fashion...They blame this trend on two converging realities: the increased pressure on financially troubled schools to provide a quick fix for disruptive children and the cutback in mental health services...
>
> *Boston Globe*, July 26, 1993

**How do <u>teachers</u> feel about this?**

# Public (K-12) Education's Hot Jalapeños

## Topics Picantes in Special Education

## Contents


| | |
|---|---|
| Foreword | i |
| On the Making of Beautiful Works | ii |
| Contributors | iii |
| Club Med: The ADD/ADHD/Ritalin Riddle | |
| The Diagnosis is ADD/ADHD | 1 |
| You Are Not Sure? | 8 |
| You Are Sure! | 10 |
| References | 18 |
| Consider This! | i |
| Full Inclusion: Does One Size Fit All? | |
| Inclusion, Right or Privilege | 1 |
| The Discovery Program | 3 |
| Are Inclusive Programs Effective? | 6 |
| Inclusion: One Size Fits All? | 7 |
| References | 15 |

## FOREWORD

Among public (K-12) education's many problems and challenges of the 90's two have become, what I have chosen to call, HOT JALAPEÑOS.

Why? because no matter who or how they are handled someone's taste buds are likely to get burned! Consider:

- The ADD-ADHD/Ritalin riddle
  and
- Full inclusion in the classroom

are heatedly, and constantly, discussed in the lay press and National Television. An Oscar winning film "Educating Peter" was recently produced about the full inclusion controversy.

But, I ask you, have the policy makers, the WASHINGTON BUREAUCRATS, the pedagogues, or anyone else, for that matter, bothered to ask the teachers themselves, those in the front lines how do they feel about these issues?

Well, of course not! So, to find out read on and - above all - get involved in the dialogue.

Enjoy!!

Carlos A. Bonilla

## *On the Making of Beautiful Works,*

## *COOPERATIVELY*

*"For years I conducted my fellow brothers in Gregorian chant. The chant may sound simple, but it required daily evening rehearsals. We didn't have an expert choir chosen by audition, we had a choir of men who happened to live in a particular monastery. A few were down right tone-deaf. Some were basses whose pitch hovered above and below the appointed note. Others were tenors whose voices tended to crack and gargle at a certain high range. Each had a different idea about how long it should take to reach the end of the piece.*

*But we sang beautiful chant, and therein is a lesson about making something extraordinary out of less than ordinary talents."*

**From "Meditations" by Thomas Moore**

**Harper Collins Publishers, 1994**

## Contributors

Lisa Dondero

Robert Hoffmann

Linda Lamoureux

Alyssa McDonald

Janis Y. Nylen

Lynne Phillips

Jeannie M. Swanson

## Editors

Carlos A. Bonilla

Joyce Goss

International Consulting Associates, Inc

Stockton, Ca. 95202

*It is easy, too easy, to see attention deficit disorder everywhere one looks. But we must not forget that underlying depression, anxiety or stress in the home environment may cause children to become inattentive or even somewhat hyperactive.*

C. Bonilla

*****

# CLUB MED:
## DIAGNOSIS ADD/ADHD

**Lynne A. Phillips, Robert S. Hoffmann,**
**Janis Y. Nylen**

## ABSTRACT

Three educators explore the ramifications of over diagnosis of Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactivity Disorder (ADHD) and the alternatives to drug therapy for affected children.

A brief background of the alarming escalation of diagnosis and medication of children with ADD is given. In addition, a teacher's perspective and behavioral modification guide to what adults can do for their children at home and in the classroom is outlined. Finally a scientific, and little known, alternative to drug treatment, is explored for children and adults with ADD/ADHD using biofeedback.

**THE DIAGNOSIS IS ADD/ADHD:**
**BUT, ARE WE REALLY SURE?**

**"The families of these misdiagnosed children are often falsely relieved that they have found and easy answer to their child's problems."**

Children fidget in their seats. A boy shuffles his feet until the linoleum wears off the floor. A student stares vacuously into space. A young girl constantly wiggles in her chair. ADD/ADHD strikes again!

The diagnosis of ADD/ADHD (Attention Deficit Disorder / Attention Deficit Hyperactive Disorder) in the Unites States is reaching epidemic proportions. The number of persons receiving medical treatment for this disorder during the period of 1990-1994 rose over 390%. This is a very alarming trend. The question must be asked, "Is it time for medical, psychiatric and teaching professionals to take a serious look at all other possible factors that could explain a person's inability to focus, pay attention or simply sit still?"

ADD is a serious neurological disorder of a person's capacity to focus. ADHD is similar to ADD, but it includes hyperactivity in the diagnosis. Criteria must be met before either of these labels can be placed on a person. The American Psychiatric Association's DSMIII-R diagnostic standards manual states that an adult or child has the ADHD disorder if they meet eight or more of the following criteria:

1. When required to do so, can not remain seated.
2. Easily distracted from the task at hand by extraneous stimuli.
3. Holding attention to a single task or play activity is difficult.

4. Frequently hops from one activity to another without completing the first.
5. Fidgets or squirms ( or feels restless mentally ).
6. Doesn't want to, or can't wait for, a turn in group activities.
7. Before a question is completely asked will invariably interrupt the questioner with an answer.
8. Has problems with job or chore follow-through. This difficulty doesn't stem from some other learning disability defiant behavior.
9. Can't play quietly without difficulty.
10. Impulsively jumps into physically dangerous activities without weighing the consequences. (Not thrill seeking).
11. Easily loses things such as pencils, tools, papers, etc., which may be necessary to complete school or other work.
12. Interrupts others inappropriately. Butts in when not invited.
13. Talks impulsively or excessively.
14. Others report that the ADHD person doesn't seem to be listening when spoken to.

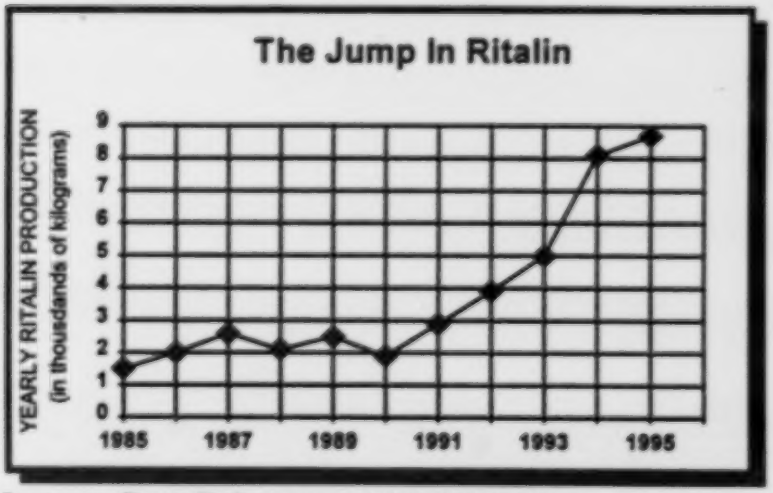
Because it was once thought that ADD ended in puberty, additional stipulations also apply to children being evaluated for possible ADHD.

- The ADD/ADHD behaviors must have started before the age of seven.
- They must not present some other form of classifiable mental illness.

- They must occur more frequently than in the average person of the same age.

The term ADHD-RS (Residual State) is now used to describe ADHD in adults.

Over the past 15 years, ADD has grown from a malady known only to a few cognitive researchers and special educators into a national phenomenon. The speed with which both the public and the professional community have embraced ADD is truly alarming. Books on the subject are flooding the marketplace, as have special assessments, learning programs, residential schools, parent advocacy groups, clinical services and medications to treat the disorder. According to the Drug Enforcement Agency, production of Ritalin is up 450% in the past four years. (See Chart ) And, the diagnosis is taking on wider definitions all the time. Next year's definition states that some children with ADD are capable of normal attention in certain specific circumstances. Thus, a few thousand more children will instantly fall into the ADD category. Where does this labeling end?




**Source: Drug Enforcement Administration**

BEST COPY AVAILABLE

**"According to the Drug Enforcement Agency, production of Ritalin is up 450% in the past four years."**

There is substantial evidence to suggest that children labeled ADD do not show symptoms of the disorder in several real-life contexts. First, up to 80% don't appear to be ADD when in the physician's office. They also appear to behave normally in other unfamiliar setting where there is a one-to-one interaction with an adult. Second, they appear to be indistinguishable from so-called normals when in classrooms or other learning environments where children can choose their own learning activities and pace themselves through those experiences. Third, they seem to perform quite normally when they are paid to do specific activities designed to assess attention. Fourth, as many as 70% of these children reach adulthood only to discover that the ADD has just gone away. Finally, and perhaps most significantly, children labeled ADD behave and attend quite normally when they are involved in activities that interest them, are novel in some way, or involve high levels of stimulation.

Teachers are jumping on the ADD /ADHD band wagon as well. In one study conducted in the US, teachers rated 49.7% of the boys as restless, 43.5% of boys as having a "short attention span", and 43.5% of the boys as "inattentive to what other say." These statistics call into question the assessments used to decide who is diagnosed as having ADD and who is not.

The most frequently used tools for diagnostic purposes are behavior rating scales. These scales are checklists made up of items that relate to a child's attention and behavior at home or at school. The assessor rates the child on a scale from 1 (almost never) to 5 (almost always) on behavioral statements like "fidgety,

**"Up to 80% of children do not appear to be ADD when in the physician's office."**

restless, ability to follow a sequence of instructions." The major problem with such rating scales is that they are inherently subjective and the outcome can be corrupted by teachers or parents who may have conscious or subconscious emotional investment in the result. For example, a diagnosis of ADD /ADHD may lead to medication or a special education placement thus relieving the classroom teacher of having to deal with a "troublesome child".

These scales really have no basis in hard fact. They are opinion based. Perhaps the troublesome child is bored or not interested in the lesson, when the assessment is being done. This will adversely affect the outcome. Such assessments don't even begin to paint an accurate picture of a child's total school experience, let alone their life experience. Even when the scales are done by teachers, parents and professionals, there is very little agreement on what is ADD or hyperactivity.

Another common assessment tool is CPTs (continuous performance tasks), the most popular of which is the Gordon Diagnostic System. This tool has no resemblance or bearing on anything the individual might do in life. It is seen as an objective score that is taken as an important measure of a child's ability to attend. But, in reality it says little about the examinee. The test is an un-interesting, computer-driven repetitive series of meaningless numbers. Ironically, the GDS is used to determine and adjust medication doses in children labeled ADD.

In speaking with fellow classroom teachers in rural Northern California the consensus opinion is that ADD and ADHD are over diagnosed. Thomas Eising, a middle school teacher for 23 years, states, "To some degree it is a band wagon thing. Doctors

seem to use ADD / ADHD as a catch all phrase to label a child, to cover something they can't pinpoint, when in fact the behavior can often be attributed to other things. There are legitimate cases of ADD / ADHD, but it is becoming too broad a diagnosis. Parents sometimes will push the diagnosis. It can too easily be a cop-out to cover the student's poor performance. In that situation it really does little more than relieve parents anxiety and guilt feelings. Although it can help make the child feel better about himself by making his behavior not his fault, it has a major drawback. The label sticks with the child all through school." He went on to say that he has only seen a classic profile ADD /ADHD child once in his career.

Another classroom teacher, Patricia Koehn, with vast experience (40 years in all grade levels) and a resident on the California Medical Board, stated that she has until recently found that Medical Doctors were very hesitant to diagnose ADD / ADHD. "Most diagnosing is done by non-medical personnel, therefore, providing an excuse for disruptive and unfocused behavior. Never have I come across any students that were thought to be true ADD /ADHD that have actual written diagnosis to back up the label. More often than not, the behavior stems from some other form of problem, i.e., problems at home (dysfunctional family situation), immaturity or Pure Character Disorder. Also inadequate behavior requirements of children by their parents can lead a classroom teacher to suspect a child of having the disorder. How can the teacher fully expect a child to focus and behave properly when the parents do not require the child to do so at home?"

Too often, a parent goes to the family doctor who quickly writes a prescription for Ritalin and does not stop to think of the other possibilities. In California the average diagnosis and subsequent medicating for ADD takes less than one minute of the physician's time. This is grossly insufficient. Diagnosing can, and often is, very tricky. Anxiety manifestations can easily mimic hyperactivity and distractible behavior, while depression can also cause ADHD-like behavior. Or, the person may have some other form of neurological dysfunction like a learning disorder. Responsible diagnosing necessitates further research before medicating.

**"Researchers also point out that the identified differences in brain regions cannot serve as a diagnostic tool. The differences may not even be the cause of ADHD but a result of treating it!"**

Recently, much investigation has been done on the brain of ADD / ADHD individuals in the form of CAT scans and MRI imaging. Researchers from the National Institute of Mental Health in Bethesda, Md., have identified three regions of the brain that differ between ADHD and normal children. The three identified brain regions have been previously implicated in the control of inhibition, planning and decision making. In these regions there is normally an asymmetry in volume between the left and right brain hemispheres, the right hemisphere region being larger. In boys with ADHD, however, that asymmetry is absent. On the right side of the brain, all three regions are smaller than normal, and thus are comparable in size to their counterparts in the left hemisphere.

Investigators also point out that the identified differences in brain regions cannot serve as a diagnostic tool, in fact, may not even be the cause of ADHD but a result of treating it! Most of the subjects studied took stimulants such as Ritalin to alleviate their

symptoms; conclusion: the search to legitimize the diagnosis of ADD / ADHD remains incomplete.

This researcher has taught at the Elementary and Secondary levels, and in the Community School system at a local Court-Ordered school where the student body was made up of students who had been expelled from public schools. In that time this researcher has met only three students possibly afflicted with this disorder. Two of those have other disabilities as well. One would think that ADD / ADHD would be very prevalent in the latter school setting, but this is just not the case.

Teaching professionals should think long and hard about referring students for ADD / ADHD testing and diagnosis. Before referral, research is needed into the background of the troublesome students. But most importantly, exhaust all alternatives in behavior management prior to suggesting an ADD / ADHD diagnosis. Above all, give your students the opportunity to learn to manage their own behaviors.

**YOU ARE NOT SURE?**

**LET'S GET THEIR ATTENTION, NOT LOSE IT**

This researcher has observed ADHD students in the classroom who have been treated with Ritalin and others who have not. Those who use Ritalin show reduced signs of hyperactivity but not increased attention spans. Visible side effects from medication include lethargy, complaints of stomach aches, headaches, fatigue and loss of appetite. Based on this researcher's observations, it is preferable for the student to function without medication.

The following successful behavior strategies have been developed for teachers and parents. Proven effective by Dr. Samuel Goldstein from the Neurology and Learning Center in Salt Lake City, Utah whose specialty is working with children and adolescents with ADD, they are useful at home and the classroom; the emphasis is on structure, consistency and stability.

Discipline should have three key elements: rules, consequences, and assertive communication. Discipline must be rooted in a value system. Using body language, eye contact, gestures, be direct and concise in communicating with a student. Provide work areas that are as free from distraction as possible. Break the assignment or household chore down into manageable work segments and give frequent encouragement and support. Involve them in activities where they excel. Have the child tutor another student or sibling. Find avenues to channel excess energy in a positive way (from office runner, to non competitive sports such as biking or swimming).

Hold the child accountable for his behavior and the decisions he makes. Help the child realize he is making choices. Stress the "stop, think and act" approach when reacting to situations. Use charts, graphs, lists, in class and at home to help structure situations and to provide feedback. Try to maintain a consistent, predictable schedule.

Train the child to verbalize softly when engaged in independent work tasks. Help the child use assignment notebooks and time charts to aid with organization.. Accept the idea that sustained concentration is difficult for the child and recognize the adult frustration threshold when working with him. Allow children

with ADD to play with younger children if they fit in. Many have more in common with younger children than with their age-peers and develop valuable social skills from this interaction..

Other educational recommendations include psychological and / or neurological testing to rule out any learning disabilities which occur in about 30% of students with ADD and to determine learning style and cognitive ability.

If parents and teachers are not certain of the status of the child, or if stimulant drugs have not helped a child focus or increase the attention span, further investigation is needed. An inappropriate diagnosis may have been made and further testing is needed. These tips and strategies have worked well for me.

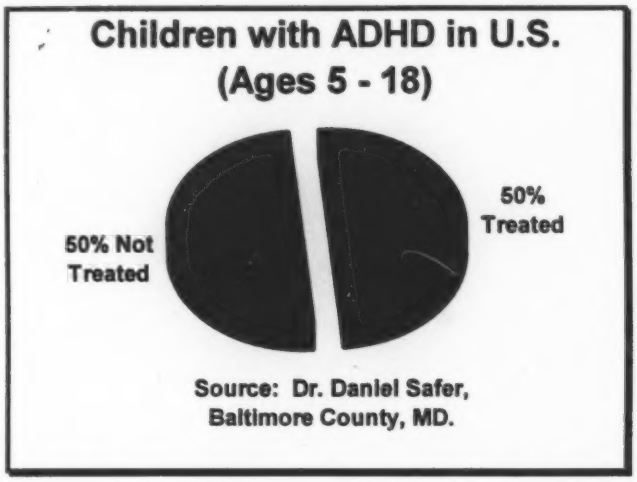
**Welcome to Club Med!**

**YOU ARE SURE!**

**A NON DRUG TREATMENT FOR ADD/ADHD?**

Much has been published about the benefits of drug treatment for children who have ADD/ADHD. "Dr. Daniel Safer,

a mental health official in Baltimore County, Md, estimates that about 3 to 4.2 percent of US youths -- from age 5 to 18 -- are being treated with stimulant drugs, predominantly methylpenidate (Ritalin). He says almost twice that number have ADD."




As authors, teachers and parents have found the use of drugs to control behavior in young children repugnant, drug companies tote the benefits. In "USA Weekend," October 27-29, 1995, Ciba-Geigy, the maker of Ritalin, says "its drug is effective in 70 - 80 percent of ADD cases, so it works. And it's safe," declares company spokesman Todd Forte. The Drug Enforcement Administration states that in a decade Ritalin production has increased nine fold. There has been a sudden and dramatic increased production between the years 1990 to 1995.

ADD/ADHD is not a disease one can catch. There is no physical test for symptoms such as a blood or urine test, or biopsy. Yet there is a growing concern that many drugs given to children have undergone few, if any, tests for safety and effectiveness. (Monika Guttman, USA Weekend, Oct. 27-29,

1995) What are the short term and long term side effects? What are we teaching our children? If you don't conform to the norm, take a pill? We know how to medicate children, but if this is a lifelong disorder, how are we helping them cope? Is there an alternative to drug treatment?

This investigation for an alternative non-drug treatment for ADD/ADHD led to the Drake Institute of Behavioral Medicine in Los Angeles. It was inspired by a six year old relative.

Drug therapy may have worked somewhat for this child, but he was not the same when "coming down" from Ritalin. He was sad. He was despondent. He did not want to explore his world or even try anything new. He just wanted to "go home and be by himself." The Drake Institute offered an alternative. He is currently in a non-drug therapy program at the Institute undergoing EEG (electroencephalograph) neurofeedback treatment.

**How does it work?**

A non-invasive, painless sensors are placed on the surface of the head to record and give him information about his own brain activation level. The information is displayed on a computer screen. Sound is also generated and changes according to his brain's activity levels. As a result, at a very young age, he is learning how to read, understand and influence his own brainwave activity. In effect, he has learned how to " wake up" a dormant part of his brain and strengthen his total brain functioning.

**"As a 24 year old I consider myself very well educated and successful with nothing wrong with me. However, my liver tests were high and I was dependent on Cyclet since I was 14. (After Ritalin and Desoxyn stopped working for me.)"**

**What are brainwaves and what do they mean for persons with ADD/ADHD?**

In 1929 Berger first made measurements of EEG waveforms. He noted two types: alpha and beta; in a relaxed state the alpha type waves were produced while with strenuous mental effort beta waves were generated. In more recent times additional waveforms (delta, theta, mu,) have been identified. Theta brainwaves are associated with unfocused behavior while beta brainwaves are produced when a person focuses and concentrates. An excess of theta brainwaves, or an insufficient amount of beta brainwaves, is found in persons diagnosed with ADD/ADHD (Frank Duffy, Michael Torello 1985).

EEG neurofeedback has been used for twenty years in the treatment of epilepsy, sleep disorders, and head injuries. The Drake Institute uses EEG neurofeedback to treat children with ADD/ADHD and a variety of other disorders. (They accept any child unless a co-existing condition such as psychosis, severe depression, autism or mental retardation is present.) As a medical institution they have the option of choosing drug therapy but prefer neurofeedback treatment for persons with ADD/ADHD.

Why? Because most patients who come to the clinic have had little or no success with other methods. According to the publication from the Drake Institute, "Some of the drugs which doctors prescribe for ADD/ADHD have not been adequately studied; the safety and long term effects of these drugs are unknown. Some physicians prescribe these medications liberally, giving high doses to severe ADD/ADHD patients...These patients...have little other choice for safe and effective treatment."

**"My 7 year old couldn't hold his attention long enough to dress himself and asking him to clean up his room was an impossible task.. The wild uncontrollable actions that accompany this malfunction of the brain took Joshua to a world of isolation and un-bearable loneliness."**

Drugs do temporarily stimulate brain functioning. On these stimulants patients are able to focus and stay on track and they can tune out distractions. But once the chemical leaves the patient's system, so do the benefits. ADD/ADHD sufferers have been reported to have mood swings when the blood levels of the chemical decreases. Because this is a life long disorder, the patient must take medication for the rest of his life. What are the alternatives to drug treatment and do they work?

The Drake Institute purports that its EEG neurofeedback treatment is very successful. According to the parents, grandparents and teacher of a six year old in treatment, it is successful so far. Will there be relapses? Not according to the Drake Institute. They claim that once a patient learns the new behavior and can control his brainwaves he does not forget how. Although my little relative is only part way through the program, those involved have noticed a dramatic change. This frantic, worrisome child, who flowed like mercury up and down stairs, who hit his sister for enjoyment, who flunked kindergarten, who did not know his letters, who could not count, whose friends could not tolerate him can now sit down and read a book just after a month and a half of sessions. He now has the ability to perform academically. He can curb his impulsive behavior and knows "when his brain is working right and when it is not."

His confidence is increasing, his social skills have improved. He recently attended a birthday party without causing disruptions or fights. The Institute claims that "... they have been able to help approximately 95% of their patient population...and that 70% of those who complete the treatment

are free of ADD/ADHD symptoms and no longer require medication. Approximately 25% experience mild to moderate improvement of their symptoms, often with a reduction in medication." They go on to say that brainwave neurofeedback through computers allows them to see and monitor how the brain works and are now using the technique to treat a variety of difficult addictive disorders and Parkinson's Disease. Are there other biofeedback treatment centers for ADD/ADHD?

According to Joel Lubar's "Discourse on the Development of EEG Diagnostics and Biofeedback for Attention-Deficit/Hyperactivity Disorders," as early as 1938 Jasper, Solomon, and Bradley presented evidence that there were EEG abnormalities in children with minimal brain dysfunction ( term for ADD). In the 1970s it was understood that stimulants had a paradoxical effect on hyperkinetic children. Satterfield (1973) proposed a hypothesis known as the "low arousal hypothesis" that children constantly sought stimulation because of their low arousal. As Lubar writes about Satterfield and his colleagues' work with ADD children, "they acted as if there were a type of "filter" blockading the impact of sensory information in each of the sensory modalities...It occurred to me that there may be a simple neurological explanation for why these children act as they do...after working with seizure patients to help them control seizures through sensorimotor rhythm (SMR) with M.B. Sterman, I noticed that these seizure patients who were in high school and college had experienced increased attentiveness and were able to focus and concentrate better." Acting on this information Lubar goes on to describe his control studies of

normal and hyperactive children. From 1980 to 1991 he and his colleagues had seen over 250 children in his clinic, the Southeastern Biofeedback Institute. Over 80% of the 250 children who received biofeedback training showed a grade point average improvement of approximately 1.5 levels. "I felt I had stumbled onto something very important, but few were trying to replicate our work."

One parent of a seven year old who went to the Drake Institute and had EEG neurofeedback treatment wrote a note of thanks: " The wild and uncontrollable actions that accompany this malfunction of the brain took Joshua to a world of isolation and unbearable loneliness...When he started a new school in September, his teacher saw no evidence of ADHD."

An eleven year old patient writes, "...I finally got some As on my report card and it felt great. One of my friends told his mother about the changes he saw go on in me. Last year it would have taken me two weeks to finish six questions in class. I couldn't remember what I had read and I often had to re-read the chapters...In class, any noise near me could and would distract me."

Granted, these glowing reports paint a rosy picture of hope for children with ADD/ADHD, but as the Drake Institute contends they are not one hundred percent successful and the treatment time consuming and expensive. According to Lubar, treatment for attention deficit disorders may take between 40 to 80 sessions. He adds, "We have never seen a child become worse after treatment. Those who have been followed into adulthood continue to function normally..." However, if these

specialist in biofeedback treatment can claim such success, why is it that so few laymen know about neurofeedback treatment?

Why aren't there more institutes like the Drake Institute sprouting like mushrooms if ADD/ADHD is as pervasive as the escalation in Ritalin drug production indicates? Why aren't more parents and teachers asking for alternative assistance? Is it because drug therapy is the easiest, most inexpensive way to control unmanageable behavior? Have drug companies become so omnipotent they control Congress and the press? Or, does our American culture make it increasingly more acceptable for doctors to prescribe, parents and teachers to demand, and kids to take drugs to curb inappropriate behavior? Aren't our children more precious and valuable than the quick and cheap fix? Shouldn't we investigate any and all non medical strategies to help children with ADD learn in the classroom especially if this is a life-long disorder? Shouldn't we raise an eyebrow of concern over our pervasive prescription drug culture that medicates rather than teaches skills about coping with frustration? After all, ADD/ADHD is not a disease that can be cured but a behavior disorder that lasts a lifetime!

## REFERENCES


American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed., rev.) (DSM -lll-R). Washington, DC: APA American Psychiatric Association. Internet Access. April 1996

Armstrong, Thomas, "ADD Does it Really Exist?" *Phi Delta Kappa* Feb. 1996 pg. 424-444

Drake Institute of Behavioral Medicine, "Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder Brochure" April 1996

Duffy, Frank H., Torello, Michael, W. "Using Brain Electrical Activity Mapping to Diagnose Learning Disabilities," *Theory into Practice* , Vol. 18, No. 7, pg. 403-408, Spring 1995

Forney, Dr., and Gausman, Robert, "Hyperactivity, ADD and Related Disorders" Stanislaus County Department of Education. Dec. 1990

Lubar, Joel F., "Discourse on the Development of EEG Diagnostics and Biofeedback for Attention - Deficit Hyperactivity," *Biofeedback and Self Regulation* Vol. 16, No. 3, 1991

Lubar, Joel F., "EEG Biofeedback and Learning Disabilities," *Theory into Practice*, Vol. 24, No. 2, pg. 106-111, Spring 1985

Lubar, Joel F., "Spectral Analysis of EEG Differences between Children with and without Learning Disabilities," *Journal of Learning Disabilities*, Vol.18, No. 7, pg. 403 - 408, Aug.-Sep. 1985

Safer, Daniel, "Getting Attention," *Knight-Ridder Newspapers*. Dec. 1995

Sandog, Bobbie, "Maybe attention disorder diagnosis is incorrect", *Honolulu Advertiser*, October 15, 1995

*Science News*, "Imaging Hyperactive Brains" Nov. 25, 195, Vol. 148, No. 22

Wallis, Claudia, "Life in Overdrive," *Time*, July 18, 1994 Vol. 144 pg. 42-50

Interviews: Thomas Eising, 8th grade teacher
Avery Middle School, Avery, CA 95223
Patricia Hoehn, 3rd grade teacher
Mark Twain Elementary, Angels Camp, CA 95222
April 28, 1996

# F.Y.I.

Dr. James Swanson, Director of The Child Development Center and Professor of Pediatrics at the University of California (Irvine) estimates that 2 percent of American girls and 5 percent of boys take Ritalin.

He feels the sudden increase in Ritalin use "is cause for alarm".

New York Times
May 15, 1996

# An Ethical Question

Is it appropriate to medicate children in the absence of a clear diagnosis with the hope they will improve their school work?

C. Bonilla

# Consider This!

| | |
|---|---|
| The Place: | San Juan Capistrano, Ca. |
| The District: | Capistrano Unified S.D. |
| The Student: | Jeremy Wartenberg (J.W.) |
| The Problem: | Jeremy, a disruptive, abusive student sold cigarettes on campus, cursed his teacher, threatened to kill a fellow student. |
| The Solution: | Expel the student, right? No, not in this case because J.W.-diagnosed as ADD-was classified as disabled under IDEA (Individuals with Disabilities Education Act). |
| The Accommodation: | The school set up special education classes for Jeremy five days a week. |
| The Result: | J.W. failed all six of his courses and continued his abusive, disruptive behavior. |
| What To Do? | Parents transferred Jeremy to a private school at a cost of over $20,000 a year. |

- Who Should Pay? The taxpayers, right? Of course, so the parents sued to force the school district to pay for private school tuition; which the school, of course, fought in the courts.

- The Verdict? The Ninth Circuit Court of Appeals ruled as follows:

    1) The District must pay all the private school tuition costs.
    2) The District must pay an additional $130,000 for J.W. family's Attorneys.

    The total award is enough to educate the equivalent of about 35 California public school students. *For a whole year!*

Setting a dangerous precedent:

In effect the court's ruling says: *a diagnosed learning disability can be used to cover for what is deemed to be unacceptable, aggressive bad behavior of unruly students!*

i

# Full Inclusion
# One Size Fits All?

**Lisa Dondero**
**Linda Lamoureux**
**Alyssa McDonald**
**Jeannie Swanson**

## INCLUSION: RIGHT OR PRIVILEGE?

Educators agree that the role of the school is to create an environment in which children can learn, grow, and become independent adults. Students learn best when their emotional, social and health needs are met. The point on which educators and administrators cannot agree is where students with special needs should receive their education. "Time was when neighborhood schools were charged with teaching reading, writing, arithmetic and citizenship. Some of us like to remember that era as the good old days, when students learned and test scores soared. But those weren't the good old days for disabled students, who were often warehoused. Nor was it a golden era for African American and Latino kids, who were often shunted into low-level programs suited to supposedly limited abilities", wrote columnist Bill Hillburg in the *Long Beach Press-Telegram.* Advocates of full inclusion would agree. One of the basic tenets of public school education is equality; they would argue that instead of proving that you have the right to be in, you start with the right to be in. It is a totally different premise.

**"Advocates would argue that instead of proving that you have the right to be in, you start with the right to be in. It's a totally different premise."**

Today, segregation still exists in special education. Despite the steady and costly expansion of special education programs, many feel that the children served have not shown the expected benefits in developing academic, social or vocational skills. The United States Department of Education publication, "14th Annual Report to Congress," reported that little, if any, progress has been made in ensuring that children who can

benefit from education in the regular class, with necessary supplementary aids and services, are in fact, receiving such an education. In many districts, two separate educational systems have developed with little or no coordination. In some schools, special and general education personnel co-exist, side by side, but do not work together. Each has his or her own classroom, is paid from separate budgets, and work from different curricular materials. This isolation and lack of coordination creates artificial barriers to achieving the promises of IDEA or the ADA.

Asserting that these two separate educational systems are unnecessarily segregated, advocates for students with disabilities, most notably, the Association for Persons with Severe Handicaps, along with general education groups including the Association for Supervision and Curriculum Development and the National Association of State Boards of Education, and special educators' groups including the Council for Exceptional Children, have issued statements favoring inclusive education, which opens general education classrooms to students with disabilities (Richardson, 1994).

**"...disability is recognized as a natural part of the human experience and in no way diminishes the rights of individuals..."**

On July 26, 1990, the American with Disabilities Act was signed into law. This civil rights law prohibits discrimination on the basis of disability by institutions providing public and private preschool, elementary, and secondary education. Under this law, disability is recognized as a natural part of the human experience and in no way diminishes the rights of individuals to enjoy full inclusion and integration in all aspects of American society (Richardson, 1994).

On the basis of this law most students should enjoy an education with their peers throughout the entire school day.

This practice of serving students with a full range of abilities and disabilities is called "inclusion". Inclusion is a philosophy of supporting children in their learning; a philosophy that holds all children can learn (Roach, 1994).

## THE DISCOVERY PROGRAM - A PROGRAM THAT WORKS!

The Discovery Program was created more than five years ago to break down the barriers faced by special education students and build bridges to equal educational access for all children. This program is currently operating at Santa Teresa Elementary School in San Jose's Oak Grove School District. The Discovery Team includes:

*four regular education teachers
*two special day class teachers
*classroom instructional aides
*students (gifted to special day)

By redesigning their classrooms and modifying their teaching styles, they have created a fully inclusive program that provides equity for all students. The Discovery Program includes students of all ability levels in a mulit-age format which is engineered and orchestrated for success. This highly planned and organized approach enables the staff to individualize instruction for all students in a technology-based, multi-modal, hands-on classroom designed to promote self esteem.

The students reflect the racial, ethnic, gender, language and ability-level makeup of the school's total enrollment. To further ensure equal access to all, the program immerses 26

special day class students into the program's four regular education classrooms. There are three combination classes (kindergarten through first grade, second through third grade, and fourth through sixth grade). This arrangement allows for developmentally appropriate grouping. Students have the opportunity to progress at their own rates within the different classes. When appropriate, they can also move between classrooms for remedial or enrichment activities.

Regular and special education staff members work together to individualize instruction for all of the students, an approach which reduces the student-to-teacher ratio. The students benefit from contact with several professions, and teachers have the benefit of a team support system. Teachers also facilitate individual or small groups at curriculum-based learning centers, which are designed to accomodate a wide range of abilities. It is not uncommon to see special day class and GATE students working cooperatively on a project. Students are allowed to roam around to creatively explore all of the centers, to make decisions, and to plan their time wisely. The students do not sit in desks in rows, instead they sit in learning centers placed strategically around the room.

The Discovery Team's philosophy is that if a classroom is engineered and orchestrated correctly, it will "hum". The teacher's job is to make sure everything is in tune. If a student is out of tune academically or behaviorally, the teacher must modify the setting, situation, or lesson to return the classroom to harmony again.

Learning centers incorporate academic skills and concepts that are designed to help develop students' higher-level thinking skills and promote life-long learning by giving the

children experiences they can relate to future studies. Students take an active part in their learning by suggesting, selecting, and working at centers, which empowers them to take an active role in their learning.

The Discovery Program is designed to appeal to a variety of learners, and interactive computer, video and laser disc technology are used extensively. Computers are used to explore all areas and levels of the curriculum. Video technology is used in the language and performing arts. Laser disc technology reinforces and provides research opportunities in social studies, art, and science.

A strong component of this program is theater arts and major musical productions and talent shows are produced throughout the year. Girls and boys of all ages, races, languages, and ability levels rehearse to create a production that allows each student to be a star and showcase his or her talent.

Providing equal access and educational opportunities to a diverse student population is the challenge facing schools today. The Discovery Program has developed a successful approach to accomplishing this task. By redesigning the regular education classroom so it can meet the needs of all students, the staff members involved have created an extraordinary learning environment that provides every student with the opportunity to discover the wonder, excitement, and joy of learning (Statler, 1994).

**HOW DO WE DO IT?**

NCERI gives the following criteria for a successful

inclusion program:

- *strong leadership (administration)
- *collaboration
- *service supports for students
- *adequate funding
- *effective parental and family involvement

These components are absolutely essential in implementing an inclusion program. Teachers need the encouragement and guidance from administrators, who can be a valuable resource in planning in-service that will help teachers welcome disabled students into their classrooms.

Professional collaboration between regular educators and special educators is an integral part of inclusion. One common misconception about inclusion is that students with disabilities will never leave the classroom for special help. Many included students will need and should have the services of support personnel, such as, speech therapists, physical therapists, and special education teachers. This support team should assist regular education teachers in making modifications that will allow the disabled student to achieve his fullest.

Districts should not use inclusion as a cost cutting measure, but rather should provide adequate funding necessary to fully comply with laws regarding the disabled. Many schools that have implemented inclusion have done so at the request of parents and families of disabled children, and these parents can be valuable resources for regular and special education teachers alike.

## ARE INCLUSIVE PROGRAMS EFFECTIVE?

The ARC, Association for Retarded Citizens, was quoted as

saying, "Research in recent years has shown special needs students educated in regular classes do better academically and socially than comparable students in non-inclusive settings; make gains in self-esteem, acceptance by classmates and social skills; and don't slow the academic progress of non-disabled students."

A standardized reading test, The Basic Academic Skills Samples(BASS), was administered at the beginning and the end of the 1990-91 school year to students with learning disabilities, as well as to their non-classified classmates. The authors concluded that 54% of the students with learning disabilities made "real growth". The results revealed that 61% of the students with learning disabilities gained ground on their peers without disabilities over the course of the school year. (Zigmond, 1991)

## INCLUSION: ONE SIZE FITS ALL?
## PART TWO

Exactly how does one help a disabled child learn to hold a spoon and eat while covering the intricacies of three digit subtraction in a class of 29? How can I create a classroom conducive to learning when an emotionally disturbed student yells constantly? What is that child doing under the table? How can I teach a disabled child for which I have no training? These are all questions regular education teachers may be asking themselves if the full inclusionists' dream becomes a reality. According to the "Education for All Handicapped Children Act" (P.L. 94-142) of 1975, youngsters with disabilities have had a right to a 'free and appropriate public

education in the least restrictive environment' " (Shanker, 18).

To some, the "least restrictive environment" means the regular education classroom in all cases. We contend that the regular education classroom is neither appropriate nor free for all disabled students. "Many believe a one-size-fits-all approach will be disastrous for the disabled children themselves" (Shanker, 19). This approach, in our minds, is not legal or ethical. In each of the reasons full inclusionists advocate their position, we have found flaws.

**"Is a severely disabled child in a wheelchair 'included' in a regular classroom setting if he or she has to spend the day at the back of the room near the exit, ignored by a busy teacher trying to cope with 29 able, active students?" (Wyllie, R., SF Chronicle, 3/11/96)**

Inclusion advocates feel that all disabled students would benefit from being in a regular classroom citing the social gains which can be made by the student. The disabled student gains positive role models, peer acceptance in the "regular" environment, and a greater sense of self-image.

**BUT...**

Although positive role models exist in the regular classroom environment, we question the "acceptance" of disabled students. Are they accepted with compassion or are they helped to blend because they are pitied? This also brings up the issue of learned helplessness. With other students "helping", the disabled student can become fully reliant on this help at the expense of learning to do the task himself.

In addition, we've seen students who have Sustained Silent Reading in the regular classroom. Instead of bringing a book they can read, such as Sullivan Book 1, they are bringing in books like Call of the Wild. There are not more than ten, two-syllable words they can read on any given page. Going through the motion is not what we're after, **FULL PARTICIPATION IS WHAT IS NEEDED.**

While studies do show that time in regular education

**"Many believe a one-size-fits all approach will be disastrous for the disabled children themselves."**

classes produce "less socially isolated" individuals, these studies show that "they are also more likely to receive failing grades and to drop out before completing high school" (CQ Researcher, 1099). The question then becomes what is more important: education or social acceptance? Obviously, full inclusionists believe the social aspect is of greater importance. As educators, we believe that education must have the greatest priority. In addition, another study found that learning disabled, behavior disordered, and emotionally disturbed individuals made more positive academic and social gains in special class placement (Carlberg & Kavale, 304).

Full inclusionists also believe that the stigma attached to the disabled child will lessen if he or she is placed in the regular classroom rather than in the isolated, run-down, weed-surrounded portable located on the outer limits of the school grounds known as special day class.

**BUT...**

Most school districts have moved to bring special education classes out of physical isolation. Most are now located alongside the regular classrooms, and the geography stigma has for the most part been removed. The special education label /stigma remains and cannot be removed simply by placing the child in a regular classroom. In order to function, these children "walk through hallways with clip-board bearing adults attached to them. Often these 'velcroed' adults were easily identifiable as special education teachers" (Ferguson, 284). Thus, the stigma continues.

A third point that full inclusionists make is that the regular education student benefits from having the disabled student in

the classroom. Regular education students learn to accept diversity in ability and develop a deeper understanding and compassion for disabled persons.

**BUT...**

Our question is at what expense? Mainstreaming students who are a danger to themselves, or those around them, is a mistake.

A 1988 United States Supreme Court ruling stated that:

> "public schools may not expel or remove disruptive, emotionally disturbed children from their classes for more than 10 days, even to protect others from physical assault, unless they get permission from the parent or a judge" (Leo, 22).

This means that a student with a behavioral disorder who constantly disrupts the class -- or even assaults a teacher or schoolmates -- cannot be excluded. This is not a fair practice for either regular education students or teachers. A classroom must feel safe for the teacher to teach or the learners to learn. In a related case, a nine-year old who broke the jaw of one staff member and three ribs of another was allowed to stay in the mainstream because of a law suit filed by his mother (Leo, 22).

**"In order to function these children walk through hallways with clipboard-bearing adults attached to them. Often these 'Velcroed' adults were easily identifiable as special education teachers."**

In each of the past two years, I have received a mid-year transfer student with behavior problems. The first year student was violent toward others and himself. He would hit, kick, and bite himself and others. This year's student breaks objects, yells, leaves the classroom, crawls under tables, and spins around on the floor. In both cases, I have been asked by parents: "Why is he in here?" My only response is that it is the child's right to be in a regular classroom. Parents often respond, "But what about my child's rights?" Good question!

**US News & World Report "But what about my child's rights?"**

What are the rights of a regular education student? It seems to be a question totally overlooked by the inclusion movement. There is no way one can expect the regular education student to receive the same amount of teacher-time when a disruptive student is present. In addition, how is a child supposed to concentrate knowing the time-bomb sitting next to him may go off at any minute. What learning takes place when a child is screaming at the top of his lungs? Placing violent and disruptive students in the regular education setting is more expensive than our teachers and students can afford in time, safety, and lost learning.

The Fifth Circuit Court has examined this issue. They established criteria for determining the validity of full inclusion in cases where "the education of other students was significantly impaired" (Lipton, 3). This same court in Daniel R.R. set forth two limits to the accommodation requirements:

(1) the reagular education teacher is not required to devote) the regular education teacher is not required to devote all or most of his or her time to the disabled child, and

(2) the regular education program need not be modified beyond recognition (Lipton, 3).

Full inclusionists point to Brown v. the Board of Education, the landmark desegregation case which stated separate facilities for different races were unequal, to show that special education is separate and therefore unequal.

**BUT...**

Equating ethnic origin with disability is:

(1) demeaning to blacks who suffer discrimination simply because of the color of their skin, and

(2) trivializes the needs of students with disabilities whose differences require accommodations far more complex than any contemplated in this court ruling, which simply disallowed skin color as a criteria for access or opportunity (Fuchs & Fuchs, 24).

Special education is unequal. It receives much more funding per student, class sizes are lower, student to adult ratios are lower, and more equipment is made available. The students in special education are receiving services they need based on an Individual Education Plan (IEP) from an educator trained in that area of expertise.

Full inclusionists say the needs of the disabled student can be met in the regular classroom with the addition of aides and a support system.

**BUT...**

In reality, the aides don't exist, and the regular education teachers have not received any training nor are they enthusiastic to increase the volume of their workload. For example, a choice was given for our staff development day: to hear a speaker talk about ADHD or to use the time in subject area committees. The moaning and groaning made the choice apparent: committee work was preferred!

Already teachers must deal with extraordinary amounts of curriculum, a wide range of student abilities, parent and administrative pressures and expectations of student performance levels, regular education student discipline problems, constant schedule adjustments, classroom disruptions, and the numerous hats they must wear to fulfill the needs of their students. To add to this load would be criminal.

Full inclustionists do not mention funding.

**BUT...**

We will. "While it costs $6,394 to educate a regular education student in the New York school system, it jumps to

$19,208 to educate the special needs child"(Shanker, 25). This cost doubles or even triples if each student is to have their own personal aide, nurse, counselor, P.E. specialist, translator, speech therapist, etc. as directed by their Individual Education Plan.

...given the reason why most states and school districts are adopting full inclusion - to save money - it is not more likely to happen for disabled children than it did for mentally ill people who were de-institutionalized years ago. Their supports were also supposed to follow them but now, as we all know, large numbers of those people are out on the streets. That's one reason that many parents of disabled children oppose full inclusion. They fear their children will lose the range of services now available and end up, like those who were de-institutionalized, with nothing (Shanker, 18).

Full inclusion, with all of its supports, will never be funded by the government. First of all, the federal government was supposed to provide 40% of the cost of educating disabled students, but since 1975, only 12% (in a good year!) has been realized. The rest has come from districts' general budgets. So what are our districts to do? Dumping under the guise of full inclusion appears to be their solution.

Full inclusionists point to the success of their program in such examples as the 1993 Academy Award winning documentary film, "Educating Peter", where a Down syndrome boy was successfully included in a regular classroom.

**BUT...**

He was successful because of the support systems very few

regular educators are receiving today: a full-time special education aide, intensive teacher training and preparation, "inclusion" specialist, lower class size, and parent education. These supports are expensive and not likely to be funded in most school systems.

**Dumping under the guise of full inclusion is their solution.**

As educators, we adhere to the policy of a free and appropriate public education for all students in the least restrictive environment. But in determining "appropriate" and "least restrictive" placement we must include the needs of the regular classroom teachers and students as well as the individual needs of the disabled student. No one particular setting is right for all special needs students. **ONE SIZE DOES NOT FIT ALL.** Where one child may perform better in a special day class, another may achieve a higher performance level totally main-streamed into a regular education class. A continuum of services must be offered in order to meet the needs of each individual child. **This is what we believe!!**

ACSA 504 Task Forece Committee, "Protecting the Civil Rights of the Disable," *Thrust for Education Leadership*, May/June 1994, pgs. 43-45.

Carlberg, Conrad and Kavale, Kenneth (1980) "The Efficacy of Special versus Regular Class Placement for Exceptional Children: A Meta Analysis." *The Journal of Special Education*, pgs. 295-305.

C Q Researcher (Dec. 10, 1993) "Should School Systems Move Toward 'Full Inclusion' of Students with Learning Disabilities in Regular Classrooms?" pgs. 1097-1099.

Deno, Stanley; Fuchs, Douglas; Fuchs, Lynn S.; Jenkins, Joseph; and Zigmond, Naomi. "When Students Fail to Achieve Satisfactorily," *Phi Delta Kappan*, December 1995, pgs. 303-306.

Ferguson, Dianne (1995) "The Real Challenge of Inclusion - Confessions of a Rabid Inclusionist," *Phi Delta Kappan*, pgs. 1-8.

Leo, John (1994) "Mainstreaming's Jimmy Problem", *U.S. News & World Report*, pg. 22.

McLeskey, James and Waldun, Nancy L, "Inclusive Elementary Programs: Must They Cure Students with Learning Disabilities to be Effective?", *Phi Delta Kappan*, December 1995, pg. 300.

Richardson, James and Stinson, Janet, "Inclusive Education", *Thrust for Educational Leadership*, May/June 1994, pgs. 38-41.

Roach, Virginia, "Supporting Inclusion Beyond the Rhetoric", *Phi Delta Kappan*, December 1995, pgs. 295-297.

Shanker, Albert (1995), "Full Inclusion is Neither Free Nor Appropriate", *Educational Leadership*, pgs. 18-21.

Statler, Larry, "From Barriers to Bridges: The Discovery Program", *Thrust for Educational Leadership*, May/June 1994, pgs. 46-48.

"Somebody Said", *Thrust for Educational Leadership*, January 1994, pgs. 2-3.

Wyllie, Romy, "Inclusion and Disabled Children" (3/11/96), *San Francisco Chronicle*.

## SPECIAL ED'S UNPRECEDENTED GROWTH

| School Year | Total Served | Change from previous year (%) |
|---|---|---|
| 1993-94 | 5,373,077 | 4.2 |
| 1992-93 | 5,155,950 | 3.4 |
| 1991-92 | 4,986,043 | 3.7 |
| 1990-91 | 4,807,441 | 2.8 |
| 1989-90 | 4,675,619 | 2.4 |
| 1988-89 | 4,568,063 | 1.8 |
| 1987-88 | 4,485,902 | 1.4 |
| 1986-87 | 4,421,601 | 1.2 |
| 1985-86 | 4,370,244 | 0.2 |

U.S. Dept of Education

**Special Education**:
The yearly per-pupil price tag? $25,000

**Regular Education:**
The yearly per-pupil price tag? $ 5,611

**PUBLIC (K-12) EDUCATION'S HOT JALAPEÑOS (ISBN: 1-879774-03-8)**

**$19.95**